

Exhibit 33

Name <u>UNK</u>		Agency Name <u>PJ VAC</u>		MILEAGE		USE MILITARY TIMES	
Address <u>33 Seaside Dr</u>		Call Location <u>33 Seaside Dr B.T.</u>		END <u>8:55</u>	CALL REC'D <u>0611</u>		
<u>Belle Terre NY 11777</u>		CHECK ONE <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Health Facility <input type="checkbox"/> Farm <input type="checkbox"/> Indus Facility <input type="checkbox"/> Other Work Loc. <input type="checkbox"/> Roadway <input type="checkbox"/> Recreational <input type="checkbox"/> Other		BEGIN <u>8:54</u>	ENROUTE <u>0621</u>		
Ph #		Call Origin <u>Med Com</u>		TOTAL <u>110</u>	AT SCENE <u>0627</u>		
Physician <u>UNK</u>		Dispatch Information <u>Bleeding</u>		HOSPITAL COMMUNICATIONS			
Next of Kin <u>UNK</u>		CALL TYPE AS REC'D. <input checked="" type="checkbox"/> Emergency <input type="checkbox"/> Non-Emergency <input type="checkbox"/> Stand-by		INTERFACILITY TRANSFER <input type="checkbox"/> Yes <input type="checkbox"/> No		IN SERVICE <input type="checkbox"/>	
		TYPE OF TRANSFER <input type="checkbox"/> BLS <input type="checkbox"/> ALS		<input checked="" type="checkbox"/> VHF <input type="checkbox"/> UHF <input type="checkbox"/> Phone		IN QUARTERS <u>0932</u>	
				<input checked="" type="checkbox"/> No <input type="checkbox"/> Communications Difficulties			

MECHANISM OF INJURY

☐ MVA (complete seat belt section) ☐ Fall of feet ☐ GSW ☐ Other ☐ Struck by vehicle ☐ Unarmed assault ☐ Knife ☐ Extrication required minutes ☐ Seat belt used? ☐ Yes ☐ No ☐ Unknown

Seat Belt Use Reported By ☐ Crew ☐ Patient ☐ Police ☐ Other

CHIEF COMPLAINT Bleeding - Medium E head a foot of bed. Dried blood noted to scalp forehead. 8 Respirations, 8 pulse

SUBJECTIVE ASSESSMENT Upon arrival in bedroom pt found dorsaland

PRESENTING PROBLEM

☐ Airway Obstruction ☐ Respiratory Arrest ☐ Respiratory Distress ☐ Cardiac Related (Potential) ☐ Cardiac Arrest

☐ Allergic Reaction ☐ Syncope ☐ Stroke/CVA ☐ General Illness/Malaise ☐ Gastro-Intestinal Distress ☐ Diabetic Related (Potential) ☐ Pain

☐ Unconscious/Unresp. ☐ Seizure ☐ Behavioral Disorder ☐ Substance Abuse (Potential) ☐ Poisoning (Accidental)

☐ Shock ☐ Head Injury ☐ Spinal Injury ☐ Fracture/Dislocation ☐ Amputation

☐ Multiple Trauma ☐ Trauma-Blunt ☐ Trauma-Penetrating ☐ Soft Tissue Injury ☐ Bleeding/Hemorrhage

☐ OB/GYN ☐ Burns ☐ Environmental ☐ Heat ☐ Cold ☐ Hazardous Materials ☒ Obvious Death

PAST MEDICAL HISTORY	VITAL SIGNS	TIME	RESP	PULSE	B.P.	LEVEL OF CONSCIOUSNESS	GCS	TS	R	PUPILS	L	SKIN
<input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> COPD <input type="checkbox"/> Cardiac <input type="checkbox"/> Allergy <input type="checkbox"/> Other (List) <u>UNK.</u> <input type="checkbox"/> Medication	Rate: <u>8</u> <input type="checkbox"/> Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored	Rate: <u>8</u> <input type="checkbox"/> Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored	Rate: <u>8</u> <input type="checkbox"/> Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored	Rate: <u>8</u> <input type="checkbox"/> Regular <input type="checkbox"/> Shallow <input type="checkbox"/> Labored	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp.	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp.	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresp.	<input type="checkbox"/> Normal <input type="checkbox"/> Dilated <input type="checkbox"/> Constricted <input type="checkbox"/> Sluggish <input type="checkbox"/> No-Reaction	<input type="checkbox"/> Normal <input type="checkbox"/> Dilated <input type="checkbox"/> Constricted <input type="checkbox"/> Sluggish <input type="checkbox"/> No-Reaction	<input type="checkbox"/> Normal <input type="checkbox"/> Dilated <input type="checkbox"/> Constricted <input type="checkbox"/> Sluggish <input type="checkbox"/> No-Reaction	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Moist <input type="checkbox"/> Dry	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Pale <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced

OBJECTIVE PHYSICAL ASSESSMENT

☐ Physical Findings Unremarkable

	Head/Neck	Upper Ext.	Chest/Back	Abd/Pelvic	Lower Ext.
1) Pain					
2) Wound					
3) Fracture/Disloc. Open					
4) Fracture/Disloc. Closed					
5) Bleeding/Hemorrhage					
6) Loss of Motion/Sensation					
7) Sprain/Strain					
8) Burn <u> </u> Deg <u> </u> %					
9) Internal					

COMMENTS Sternum exposed proximal end appearing moved toward neck

Sig 50

TREATMENT GIVEN		MEDICAL CONTROL INFORMATION		Insurance Data	
<input type="checkbox"/> Airway Cleared <input type="checkbox"/> Oral Airway <input type="checkbox"/> Esophageal Oblurator Airway/Esophageal Gastric Tube Airway (EOA/EGTA) <input type="checkbox"/> Endotracheal Tube (E/T) <input type="checkbox"/> Oxygen Administered @ <u> </u> L.P.M. Method <u> </u> <input type="checkbox"/> Suction Used <input type="checkbox"/> Artificial Ventilation Method <u> </u> <input type="checkbox"/> C.P.R. in progress on arrival by: <input type="checkbox"/> Citizen <input type="checkbox"/> Firefighter <input type="checkbox"/> Police Officer <input type="checkbox"/> C.P.R. Started @ Time <u> </u> Time from Arrest Until C.P.R. <u> </u> Minutes <input type="checkbox"/> EKG Monitored (Attach Tracing) [Rhythm(s)] <u> </u> <input type="checkbox"/> Defibrillation/Cardioversion No. Times <u> </u> With <u> </u> Watt/Sec. <u> </u>		<input type="checkbox"/> Medication Administered (Use Continuation Form) <input type="checkbox"/> IV Fluid <u> </u> No. Established <u> </u> No. of Attempts <u> </u> <input type="checkbox"/> Mast Inflated (Time Inflated: <u> </u>) <input type="checkbox"/> Bleeding/Hemorrhage Controlled (Method Used: <u> </u>) <input type="checkbox"/> Spinal Immobilization <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Limb Immobilized by <input type="checkbox"/> Fixation <input type="checkbox"/> Traction (Heat) or (Cold) Applied <input type="checkbox"/> Vomiting Induced @ Time <u> </u> Method <u> </u> <input type="checkbox"/> Restraints Applied, Type <u> </u> <input type="checkbox"/> Baby Delivered @ Time <u> </u> In County <u> </u> <input type="checkbox"/> Alive <input type="checkbox"/> Stillborn <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other			

DISPOSITION (See list) <u>pt sig 50 not transported</u>		DISP. CODE <u>0110</u>		CONTINUATION FORM USED <input type="checkbox"/>	
IN CHARGE <u>K. M. Law</u>		DRIVER'S NAME <u>to E. Curley</u>		NAME <u>K. Hadwick</u>	
<input type="checkbox"/> EMT <input type="checkbox"/> AEMT # <u>070320</u>		<input type="checkbox"/> EMS-FR <input type="checkbox"/> EMT <input type="checkbox"/> AEMT # <u>070800</u>		<input type="checkbox"/> EMS-FR <input type="checkbox"/> EMT <input type="checkbox"/> AEMT # <u>124483</u>	

① Kenneth Milan Milan- Resp Ther. Mother
17 Hillcrest Av
Port Jeff 11777
473-2608. H
473-1320 wk ext 4088 2300-0700

② Kelly Harowick
201 Liberty Av
Port Jeff 11777
473-5284 H
473-1367. Ambulance

③ Ethel Curley R.N. School
P.O. Box 521 P.J. S.C.
Crescent Rd Belle Terre. 11777
331-9235. H R.N.
444-2050. W Univ. Hosp